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Survey of the Commissioning Nurse Leaders' Network Membership 2015: Summary of Results

Produced on behalf of Centre for the Critical Research in Nursing & Midwifery
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Executive summary

This report presents the findings from the 2015 online survey of nurses working in commissioning roles either as Governing Body nurses (GBNs)¹ and nurses working for Commissioning Support Units (CSUs) which support CCGs. The survey was undertaken in collaboration with the Commissioning Nurse Leaders' Network (CNLN). We present the results from the online survey in the context of current policy developments and some recommendations.

Data collection was carried out using an online survey of all commissioning nurse members of the CNLN between 11th June and 6th July 2015. All of the sample provided by NHS England (n=238) were sent a personalised email (addressed to them by name) which included an information sheet about the survey and a link to the online survey. The response rate was 40.7% (n=97) which was similar to the response rate for the survey of CCG nurses carried out in 2014 by NHS England (41%, n=69).

Findings included in this report refer to all respondents in the survey (GBNs and nurses working in CSUs) unless otherwise indicated.

Demographic profile and previous experience

92.8% of respondents worked for one or more CCGs; 7.25% of respondents were employed by a CSU.

Respondents were mostly female, over 50 years of age, of White or White British ethnicity, with substantial clinical, managerial and Board experience.

Working patterns

75% of the respondents had worked within CCGs or CSUs for more than two years; a relatively small proportion (7.8%) had been in their post for less than one year.

79.7% of respondents worked full-time (37.5 hours a week or more) and the majority (82.2%) worked within one CCG or CSU.

Just under 18% of GBNs worked for more than one CCG and a majority of these respondents felt that all their CCGs worked well together (56.3%) but 25% said that only some are working together and 18.8% said that none were working together.

A large majority of GBNs (81%) worked in full-time statutory (executive) roles with just 14% working as part-time statutory (executive) roles.

¹ The whole membership of the CNLN i.e. those nurses who self-identify as commissioning nurses, were invited to participate in the survey. All of the respondents to the survey worked for a CCG (either as a GBN or in another commissioning role) or a CSU. In this report we refer to GBNs except where we highlight results specifically referring to nurses working on CSUs.

Tensions between CSUs and CCGs.

Amongst nurses who worked in CSUs, more than half of respondents (57.2%) said that they were fairly or extremely dissatisfied with the impact of their work on the CCG (28.6% in each category). A large minority (42.9%) said that they were fairly satisfied. Comments in open-ended questions suggested that this may be explained by perceptions that CSUs are not respected or valued by CCGs or that CCGs may sometimes make unreasonable demands on CSUs.

GBNs' motivation, roles and experiences of working in CCGs.

The reasons for wanting to be a nurse on a CCG, which GBNs cited most frequently were: having an impact in population health; being an advocate for patient interests and ensuring a nursing influence on commissioning services.

GBNs' perceptions of their influence of their roles on decision-making in CCGs.

GBNs were much more satisfied with their impact on CCGs (84% very or fairly satisfied) than were nurses working in CSUs. In addition, more than 90% of GBNs were extremely or fairly satisfied overall with the contribution they made to the work of the CCG.

Two-thirds of GBNs said that they chair at least one committee, most commonly the Quality Committee / Quality and Risk Committee or the Safeguarding Committee.

Over 90% of GBNs said that their CCG has an executive management board. Of these, 79.7% reported that they were a member of that board. A large majority of GBNs who were on CCG management boards (89.1%) felt that they were extremely or fairly influential on these boards.

Amongst those not on executive management boards, the reason most frequently given was that their role was not configured as an executive one and therefore they were not on the board and not able to influence decision making at this level.

A large majority of GBNs (85.1%) felt that they were extremely or fairly influential in CCG decision-making generally.

Nearly all respondents (92.7%) considered that the statutory nursing role was important (extremely or fairly) to the work of the CCG.

GBNs' views on the perceived purpose of CCGs.

Improving the population's health was considered to be the most important goal of their CCG by a significant majority of respondents (61.6%); 19.2% felt commissioning was the most important goal of CCG work; 9.6% of respondents believed service redesign and meeting financial targets were the most important goals of their CCG.

GBNs' perceptions of their ability to be leaders in CCGs.

95.8% of respondents felt that they had a leadership role within their CCG. More than half of respondents (52.9%) said that they were 'extremely confident' in carrying out their leadership role and a further 38.2% were fairly confident.

Conclusions

These are positive, albeit self reported, findings regarding the nursing role in CCGs and CSUs. Some of the findings suggest causes for further investigation:

- The open-ended responses show that the influence and impact of the GBN role may in some instances be limited by certain assumptions or ways of working, particularly the perception that the GP is the lead clinician in the CCG.
- There is evidence in the findings that GBNs were much more satisfied with their impact on CCGs than were nurses working in supporting commissioning in CSUs.

Consequently, achieving the goals of the CCGs, including developing a nursing leadership role in commissioning on CCGs, may therefore be under threat if the contributions of GBNs and other nurses working for CCGs or in CSUs, go unrecognised or are under-utilised.

1 Introduction

This report presents the findings from the 2015 online survey of nurses working in commissioning roles either as Governing Body nurses (GBNs) and nurses working for Commissioning Support Units (CSUs) which support CCGs. The survey was undertaken in collaboration with the Commissioning Nurse Leaders' Network (CNLN), set up in 2012 by National Health Service England (NHS England) and the Royal College of Nursing (RCN), to support newly appointed GBNs in England. This report presents the results from the online survey with an analysis of these in the context of current policy developments and some recommendations.

1.1 Background

1.1.1 CNLN

The CNLN was set up in partnership between NHS England and the RCN to support nurses working in senior commissioning roles. The CNLN has undertaken two online surveys of GBNs since 2013 (McCann et. al 2014). In the current report (2015), in collaboration with Professor Helen Allan and Mr Mike O'Driscoll at Middlesex University, the survey was developed to integrate work from a literature review (Allan et al, in press) and findings from ethnographic work with two CCGs in the London area (Allan et al in press).

The annual CNLN survey aim is to evaluate the 'success of the network in supporting and developing the role of CCG nurses' (McCann et. al 2014, 15). The CNLN survey objectives were to assess respondents' self-reported levels of confidence and competence in commissioning and leadership skills, and to assess the changes that had occurred over the year. The results provided evidence of the key challenges and issues faced by senior commissioning nurse leaders. The 2015 survey was consequently distributed, and data analysed by Professor Allan and Mr O'Driscoll independently of the CNLN.

1.2 Governing body nurses

Following the Health & Social Care Act (DH 2012a) in the United Kingdom (UK), and a major restructuring of the National Health Service (NHS) in England, the National Health Commissioning Board (since 2013, NHS England) was created as a national commissioning board which devolves responsibility for local commissioning to CCGs. Local CCGs plan, agree and monitor health and social care services.² CCGs took over the design and commissioning of most health services in England on the assumption that commissioning by clinicians would lead to improved decision-making, improved outcomes for patients and more effective use of resources (DH 2011). Indeed CCGs have a legal duty to assure quality across commissioned services in secondary care and, from 2015-16, have additional

² National Health Service England defines commissioning as 'not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment' (NHS England 2015).

optional responsibilities including general practice performance management and reviewing GP contracts (Holder et al. 2015).

The Governing Body of each CCG includes a number of statutory roles: a Chair, an accountable officer, a finance officer, two lay members, a clinical member, and a clinical member registered nurse, subsequently known as a GBN. In order to meet the needs of the local population, the commissioning cycle comprises the processes of assessment and planning, implementation and monitoring services, and evaluation (Leach and Burton Shepherd 2014). The RCN successfully argued that nurses could bring unique perspectives and skills to the work of CCGs, and that, to promote excellence in healthcare: “Every CCG must have a nurse on their Governing Body” (RCN 2012a)³. Such nurses were expected to have significant experience in leadership and management (RCN, 2012a). Their role as a Governing Body board member is different to nurses reporting to the CCG Governing Body members, such as nurses working in Commissioning Support Units⁴, and nurses working in primary care, in GP practices, e.g. practice nurses, who might be well known to clinicians sitting on local CCGs⁵. The commissioning *and* leadership components of the GBN role were highlighted at a very early point in the introduction of these new nursing roles on CCGs. The GBN’s role is to bring a nursing perspective or leadership, an understanding of nursing (DH 2011, 3), and to “[P]romot[e] nursing involvement at every level in the new commissioning structure” (RCN 2012a, 6). However, as with other senior nursing roles (Burdett Trust for Nursing 2006), concerns have been raised about whether senior nurses, including GBNs, can be effective in advancing a nursing perspective; what such a perspective might be; what the demands of the role might be; and what support may be needed. Furthermore, despite the RCN (2012a) advocating strongly that nursing leadership was essential to CCGs in achieving their targets in terms of “[Q]uality, safety, effectiveness and efficiency...successful authorisation and continuing improvement” (2012a, 1), it is unclear what they mean by nurse leadership (Allan et al. in press).

Commissioning support units (CSUs) support CCGs through providing services related to commissioning that enable clinical commissioners to achieve the health goals for their local population. Nurses work in CSUs in various capacities to support the CCG itself rather than the GBN. While many of these nurses might have a nursing background, few of them work as nurses in their capacity as nurses on CSUs (Allan et al. in press).

³ The RCN is the main professional organisation in the UK for nurses and health support workers.

⁴ CSUs are intended to provide support to CCGs by providing business intelligence, health and clinical procurement services and other back-office administrative functions, including contract management. Nurses working in CSUs often call themselves commissioning nurses.

⁵ Practice nurses were widely considered early in 2013 to have been the nurses most likely to be appointed as GBNs. But the requirements for these senior roles mean that they cannot work for the same services the CCG commissions from, i.e. the Governing Body nurse has to have some distance from the service s/he commissions.

2 Methodology

2.1 Data collection

Data collection was carried out using an online survey method between 11th June and 6th July 2015.

The survey sample (n=238), representing GBNs and other commissioning nurses (i.e. those working in CSUs) who were members of the CNLN in England at 11th June 2015, was provided to the research team by NHS England.

All of the sample were sent a personalised email (addressed to them by name) which included an information sheet about the survey a link to the online questionnaire. After three reminders, a total of 97 responses were received, representing a response rate of 40.7% which is above average for an online survey and comparable to the response rate obtained by NHS England in its survey of CCG nurses the preceding year (Mc Cann et. al, 2014).

The survey contained opportunities for open- ended responses to a number of questions which added to the richness of the data collected and ensuing analysis. Analysis of the open-ended responses are presented along with quantitative findings in chapter 4.

3 Findings

The main findings from the survey, both quantitative and open ended responses, are presented below with commentary and graphics. **Findings presented in this report refer to all respondents to the survey unless otherwise indicated.** The 2015 survey included some new questions specifically for nurses working in CSUs. These include questions about their prior experience, the impact they feel their role in the CSU has on the CCG, and how important they perceive the work of the statutory nursing role, the GBN, is to the CCG. Where these findings are presented they are clearly labelled as 'CSU respondents only'.

3.1 Demographic profile of survey respondents

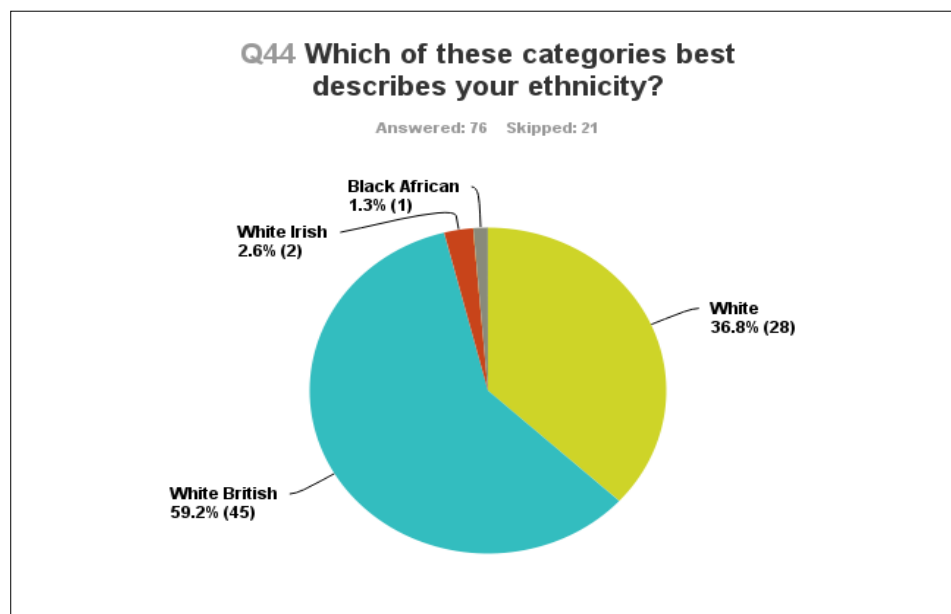
It is standard practice in survey reporting, to include a demographic profile of the respondents. Being transparent about the demographics of respondents allows readers to put the data in context and may also allow any obvious bias in the sample to be identified. In the context of this survey, the demographic profile of respondents may also be important in the context of succession planning and the need to widen participation in nurse leadership (Mc Cann et. al, 2014:17).

3.1.1 Gender

89.3% of respondents are female and 10.7% are male.

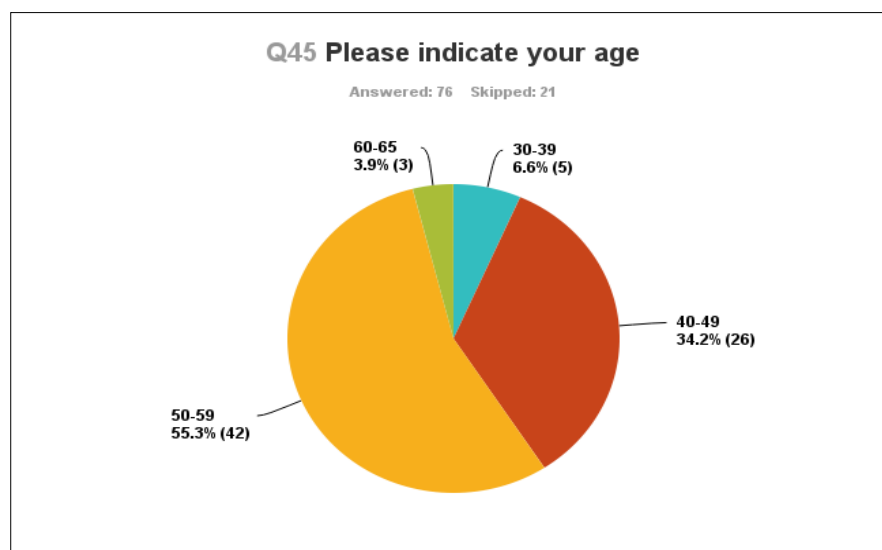
3.1.2 Ethnicity

59.2% of respondents described themselves as White British and a further 36.8% described themselves as 'White', making a total of 96% White British or White. Two respondents (2.6%) were White Irish and 1 respondent (1.3%) was Black African.



3.1.3 Age

More than half of respondents (55.3%) were aged 50-59 and a further 3.9% were aged 60-65.



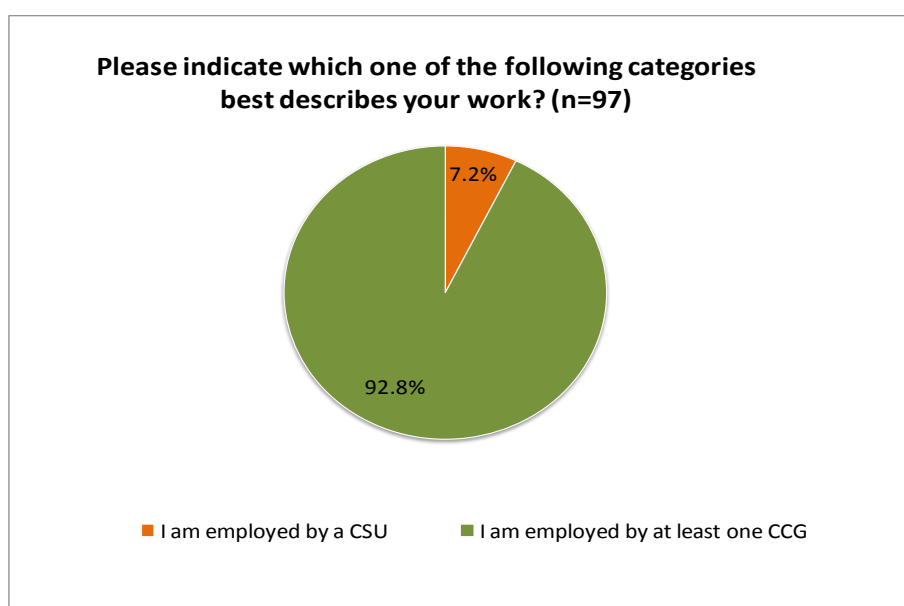
The findings regarding the demographic profile of respondents are in line with those of Mc Cann et. al (2014:17) who note:

“Commissioning nurse leaders need a level of experience of leadership and strategic thinking, and so have been recruited in the main from existing senior nurses This means they are relatively mature, predominantly female and white British”.

Mc Cann et. al⁶ argue that careful succession planning is needed so that future nurse leaders are more representative of the nursing workforce and the range of populations served by CCGs, and that one way to achieve this would be through raising awareness of commissioning as a career option.

3.1.4 Respondents' employers

The vast majority of respondents (92.8%) were employed by a CCG; 7.2% of respondents were employed by a CSU.

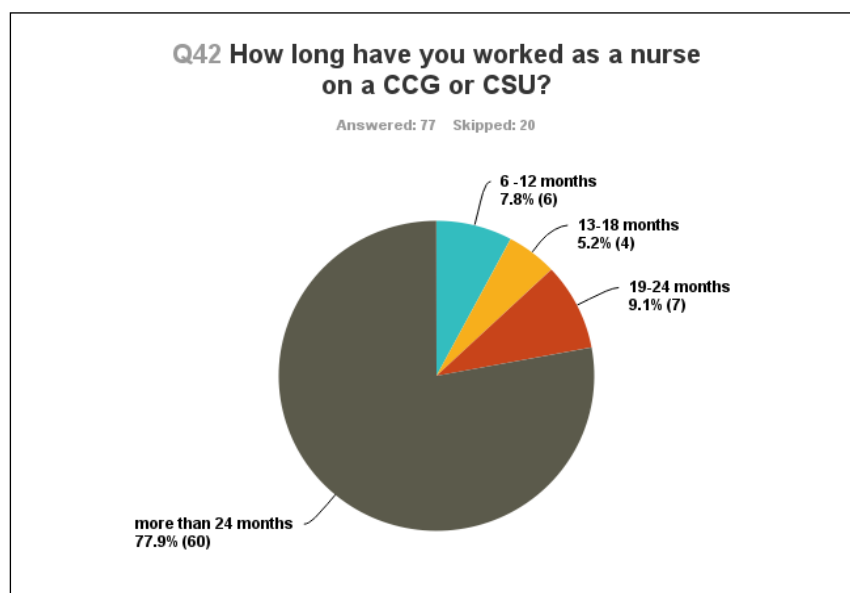


⁶ op. cit

There were two 'other' responses: one was a 'GBN for secondary care as an appointee' and one reported that they had been employed by a CCG until shortly before the survey.

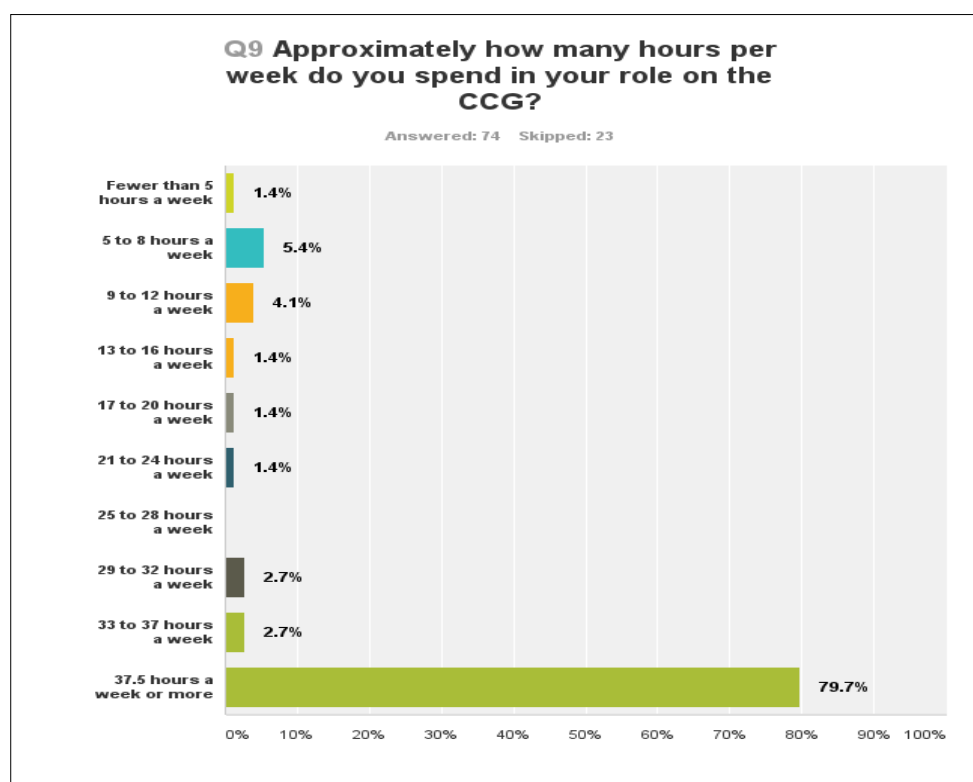
3.1.5 How long have you worked as a nurse on a CCG or CSU?

More than three-quarters of respondents had been in their posts on the CCG or CSU for more than two years; a further 9.1% had been in post for between 19 and 24 months and 5.2% had been in post for 13 to 18 months. A relatively small proportion of respondents (7.8%) had been in post for less than a year.



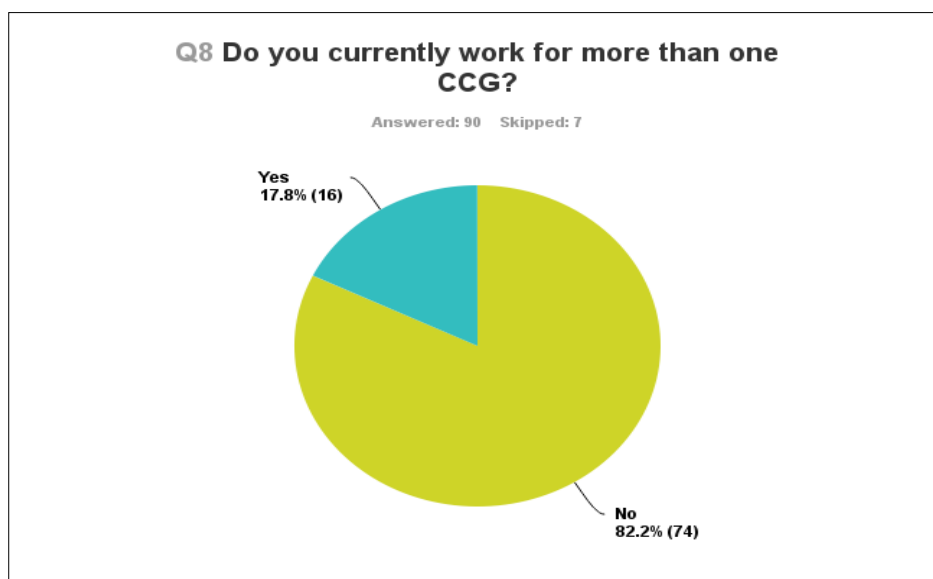
3.1.6 Hours worked per week in CCG role

79.7% of respondents said that they worked 37.5 hours a week or more in their CCG role. The remaining 20% of respondents were fairly evenly distributed across the remaining categories, although no respondents said that they worked 25 to 28 hours a week. This suggests that most respondents to the survey were in full-time posts in their CCG or CSU role.



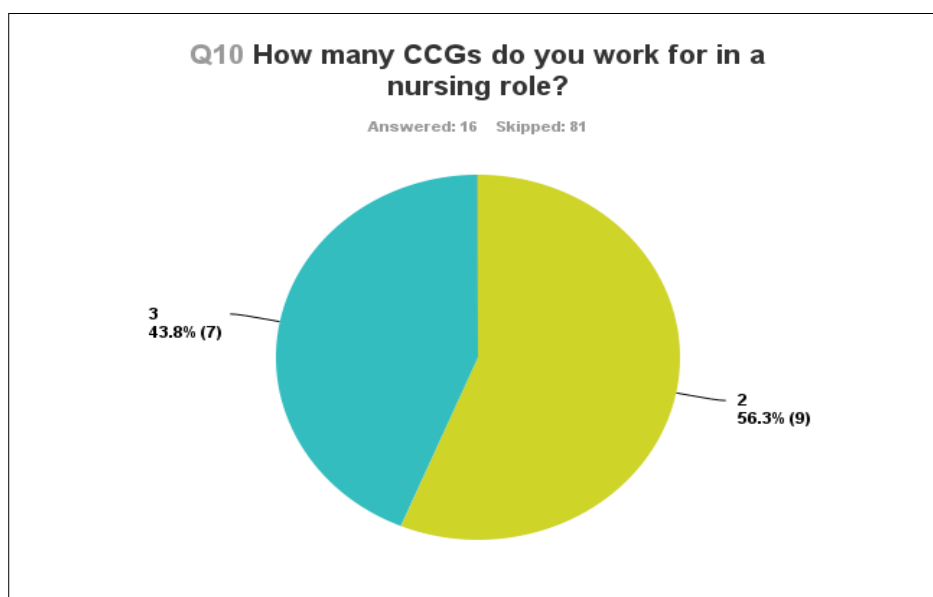
3.1.7 Number of CCGs which respondents work for

Just under 18% of respondents said that they currently worked within more than one CCG.



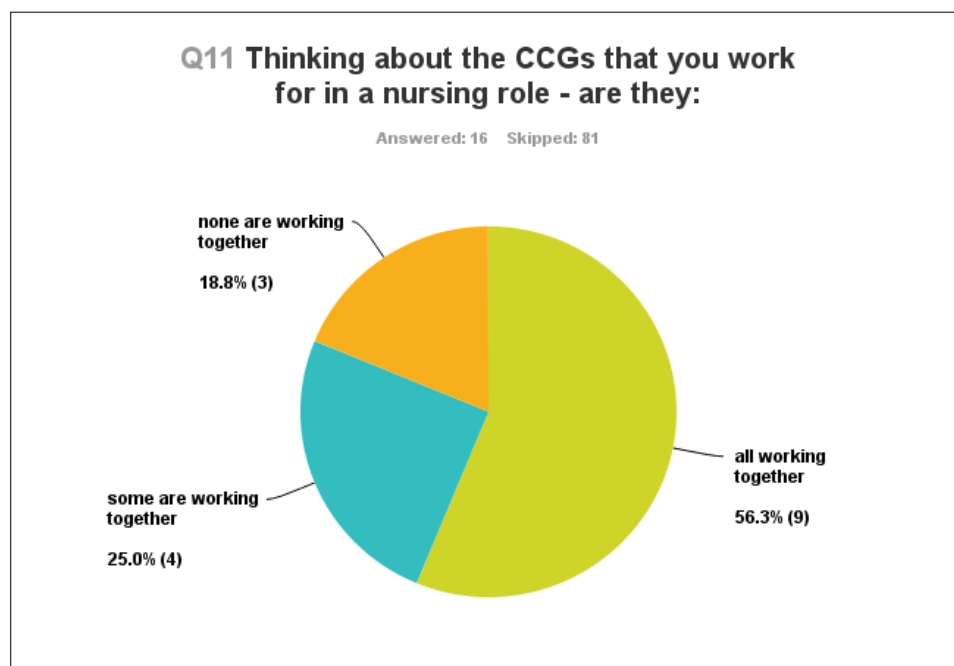
3.1.8 Those working for more than one CCG – how many CCGs are they working for?

Of those respondents who worked within more than one CCG (n=16), 43.8% worked within three CCGs and 56.3% worked within two CCGs.



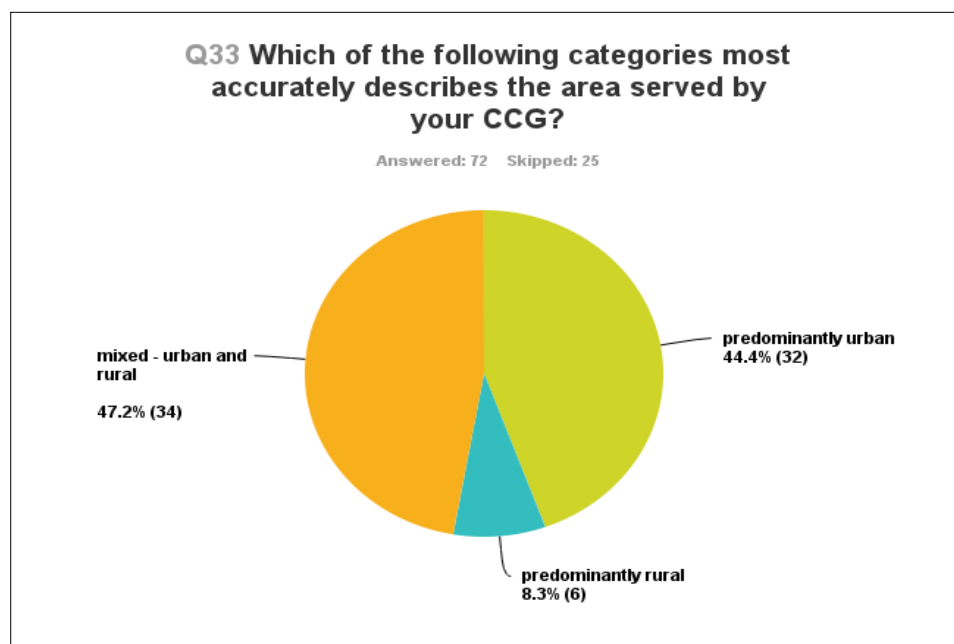
3.1.9 Those working for more than one CCG – are CCGs working together?

Again, looking just at those respondents who said that they worked within more than one CCG, just over half (56.3%) said that all the CCGs they worked within were working together; a further quarter felt that some of the CCGs they worked within were working together and 18.8% of those who worked within more than one CCG felt that none of them were working together.



3.1.10 Characteristics of area served by CCG

Just under half of respondents (47.2%) reported that the area served by their CCG was mixed (urban and rural) and 44.4% said that the area served by their CCG was predominantly urban and 8.3% said that their CCG served a predominantly rural area.



3.1.11 Size of population served by respondent's CCG

A majority of respondents (58.4%) said that their CCG served a population of less than 300,000.

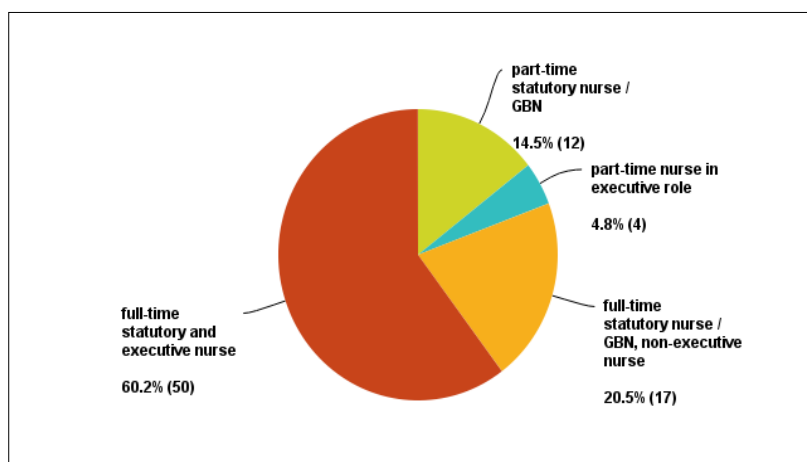
Size of population served by CCG	% of respondents (n=72)
Under 50,000	0.0%
– 50,000 to 99,999	1.4%
– 100,000 to 149,999	9.7%
– 150,000 to 199,999	15.3%
– 200,000 to 249,999	16.7%
– 250,000 to 299,999	15.3%
– 300,000 to 349,999	13.9%
– 350,000 to 399,999	2.8%
– 400,000 to 449,999	2.8%
– 450,000 to 499,999	4.2%
– 500,000 to 549,999	6.9%
– 550,000 to 599,999	4.2%
– 600,000 to 649,999	2.8%
– 650,000 to 699,999	0.0%
– 700,000 to 749,999	2.8%
– 750,000 to 799,999	0.0%
– 800,000 to 849,999	0.0%
– 850,000 to 899,999	0.0%
– 900,000 to 949,999	0.0%
– 950,000 to 1 million	1.4%
– More than 1 million	0.0%
Total	100%

3.2 Working patterns and previous experience

3.2.1 CCG nurse role

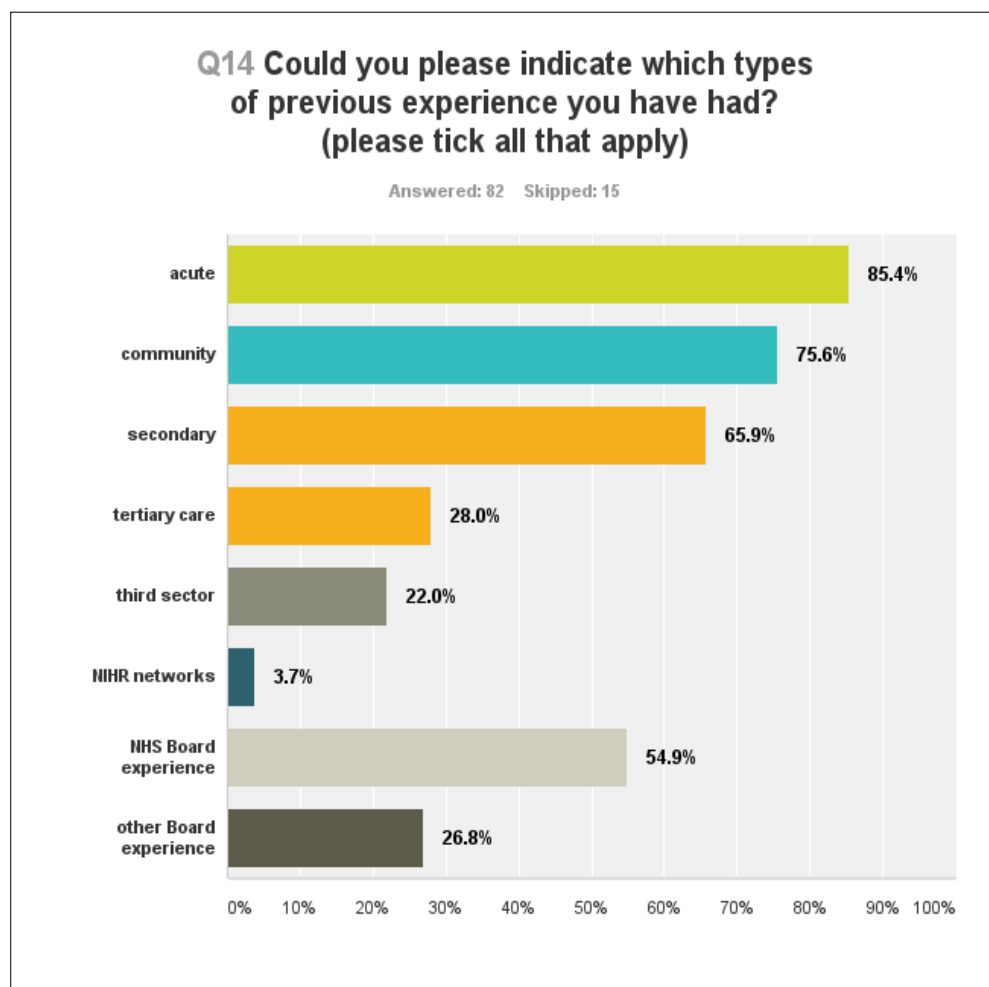
A majority of respondents (60.2%) reported that their CCG nurse role was as a full-time statutory/executive nurse. One in five (20%) said that their role was full-time statutory nurse/GBN or non-executive nurse. 14.5% of respondents said that their role was part-time statutory nurse or GBN and 5% said that their role was full-time statutory nurse/GBN, non-executive role. This confirms the finding in Q9 that around 80% of respondents were full-time. (See 3.1.6).

Q13: Role of GBNs in CCGs (n=83)



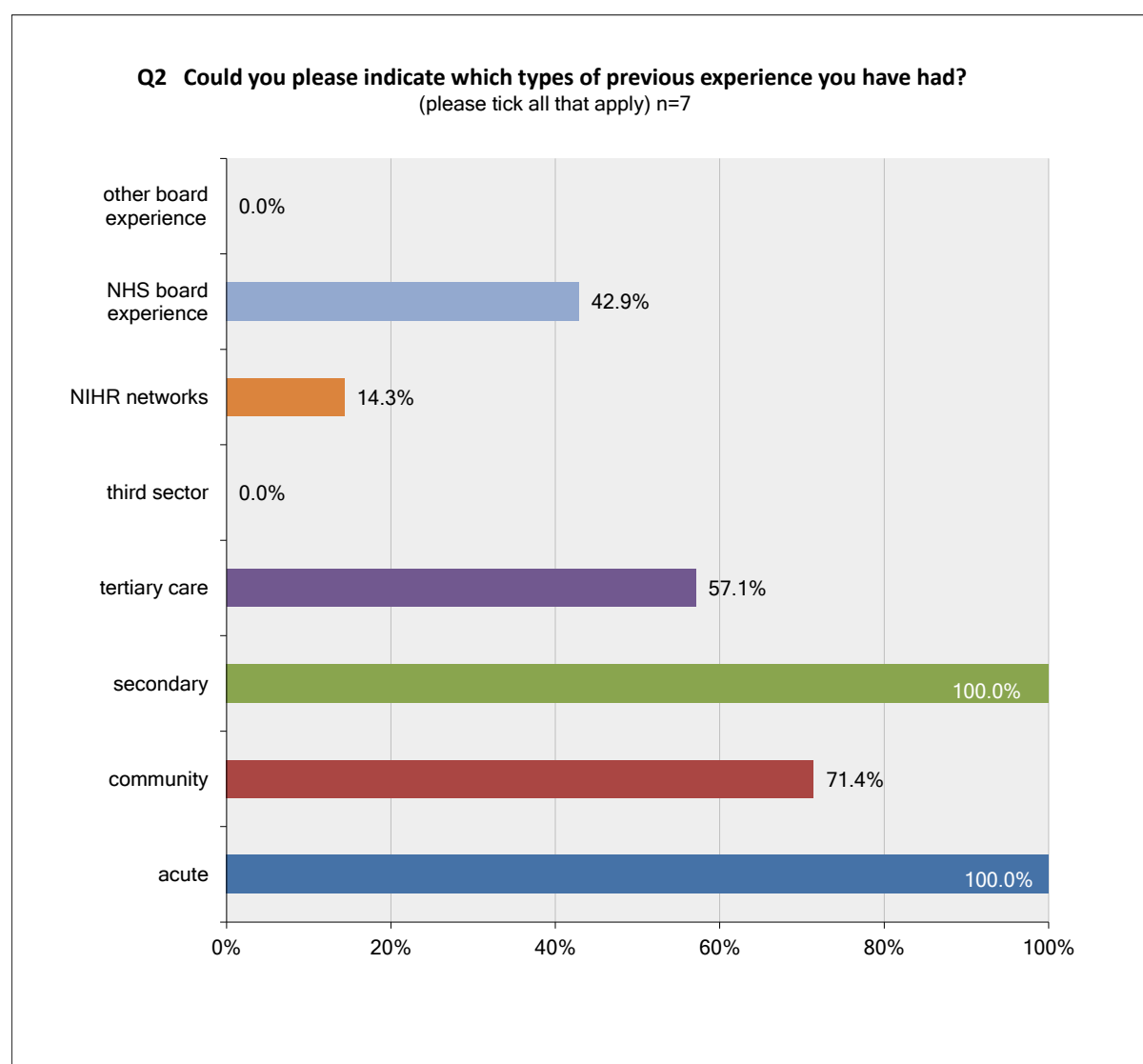
3.2.2 GBN respondents only - previous experience

The vast majority of respondents had acute experience and just over three-quarters had community experience. Two-thirds had secondary experience and 28% had tertiary care experience. In terms of non-clinical experience, 54.9% had NHS Board experience and 26.8% had other board experience; 22% had third sector experience and 3.7% had experience of NIHR networks.



3.2.3 CSU respondents only - previous experience

All respondents had acute and secondary care experience. A large majority had experience of delivering community care and 57.1% had experiences with tertiary care. More than four in ten (42.9%) said that they had NHS Board experience. No respondents had third sector or 'other' board experience⁷.

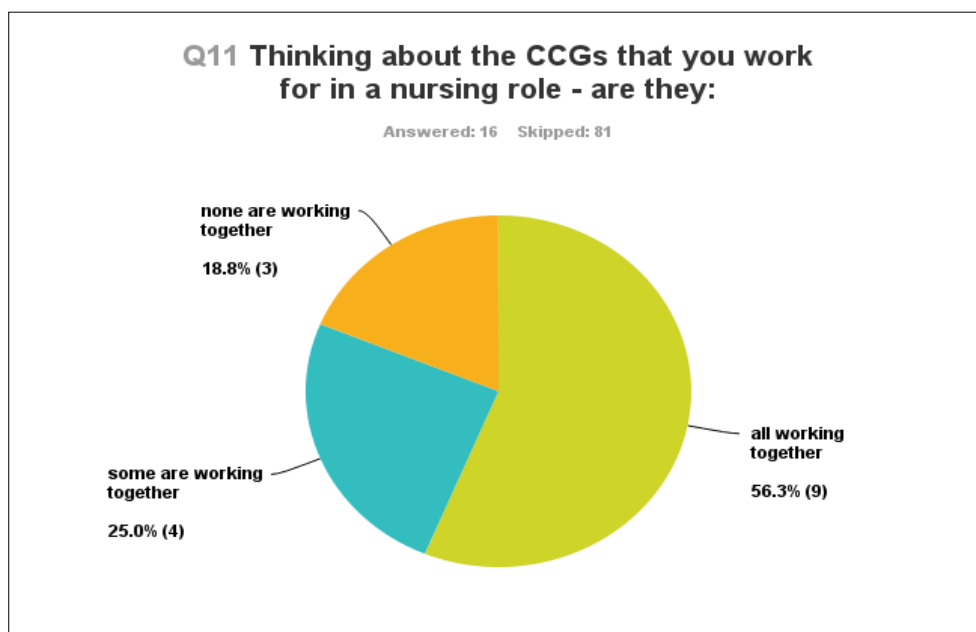


The number of CSU respondents was small (n=7) and therefore it would be unwise to read too much into differences compared to the GBN respondents. Subject to that caveat, the CSU respondents were more likely than GBNs to have experience of NIHR networks and tertiary care.

⁷ There were two 'other' responses: "Independent Sector Hospitals Healthcare abroad" and "Ambulance Trust".

3.2.4 Those working for more than one CCG – are CCGs working together?

Again, looking just at those respondents who said that they worked within more than one CCG, just over half (56.3%) said that all the CCGs they worked within were working together; a further quarter felt that some of the CCGs they worked within were working together and 18.8% of those who worked within more than one CCG felt that none of them were working together.

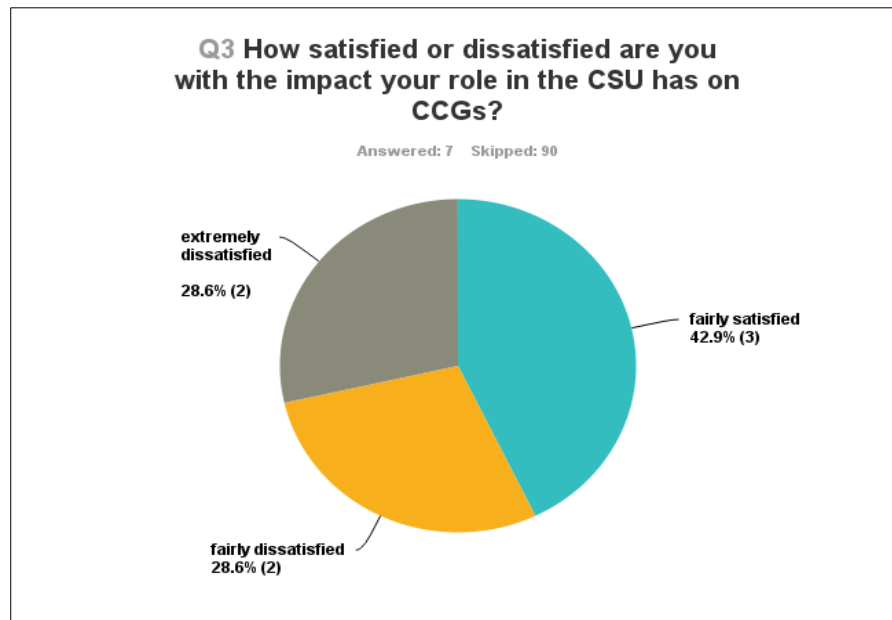


3.3 Tensions between CSUs and CCGs

The survey included some specific questions for nurses in CSUs, which elicited some interesting data on the relationship between CCGs and CSUs from the perspective of CSU nurses.

3.3.1 CSU respondents only - impact of their work on CCGs

Those who worked within a CSU were asked how satisfied they were with the impact of their work in CSUs on CCGs. More than half of respondents (57.2%) said that they were fairly or extremely dissatisfied (28.6% in each category). A large minority (42.9%) said that they were fairly satisfied.



Some of the comments in the open-ended data may help to explain this apparently high level of dissatisfaction:

“CCGs do not appear to value the wealth of knowledge and skills that each CSU has in terms of nursing experience and do not trust the recommendations based on that knowledge”

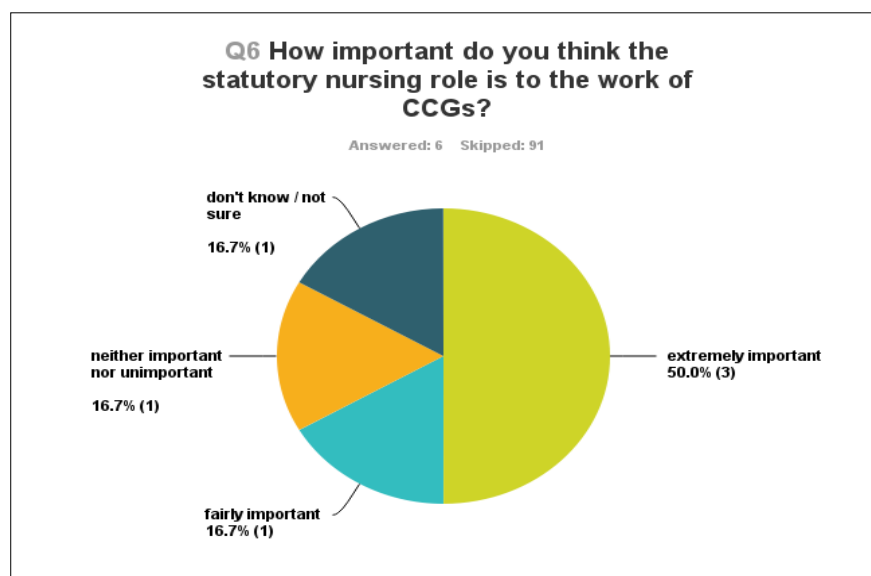
“The relationship between the CSUs and CCGs is not fully matured”

“The power imbalance between CCGs and CSUs. CSUs are expected to meet multiple CCG demands, often unrealistic and therefore “feel” set up to fail”

“My role - i.e. supporting CCGs limits my ability to influence patient and population outcomes. Most CCG nurses are less experienced and seen as junior within CCGs and the operational side of CCG responsibilities often overrides the clinical outcome responsibilities. CCGs often see us as back office rather than expert advisors and frequently fail to follow advice of CSUs”.

3.3.2 CSU respondents only - importance of statutory nursing role to work of CCGs

Two-thirds of respondents in CSUs (66.7%) considered that the statutory nursing role was extremely or fairly important to the work of CCGs.



The open ended responses to this question add some insight into why respondents feel that the statutory nursing role is important to the work of the CCG.

“This [the statutory] role provides a balance to the financial case; the primary purpose is to make sure clinical services are clinically safe, effective and provide a good experience”

“Many of the commissioning decisions involve areas where care is delivered by nurses”

“CCG Boards are dominated by GPs (General Practitioners) who see life through the lens of a GP. Historically the DoN (Director of Nursing) was the conscience of the organisation, this is waning”

However, one CSU respondent said “I have seen little impact of what the statutory role does”.

3.4 GBNs' motivations, roles and experiences of working on CCGs

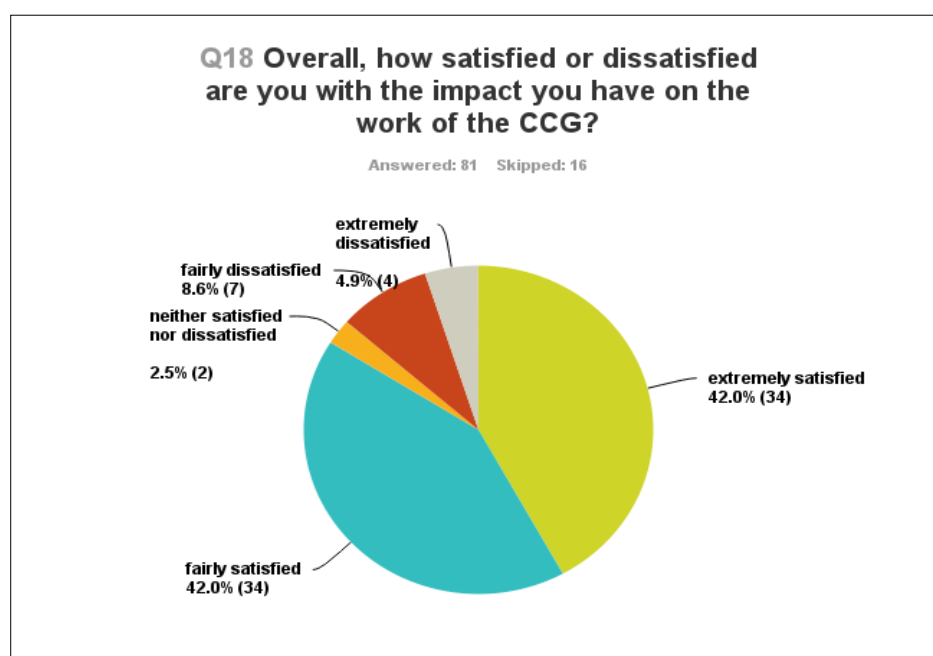
The next section presents the responses to questions about GBNs' experience, roles and motivations for becoming a GBN. These questions were not asked to nurses working on CSUs.

3.4.1 Current experience of chairing committee/s and any other responsibilities

Two-thirds of respondents (n=54) said that they chair at least one committee. Respondents were asked which committees they chair and what other responsibilities they have. The main committees specified by respondents were the Quality or Quality and Risk Committee and the Safeguarding Committee, although two respondents explained in open responses that these committees had recently appointed a lay chair. One or two open responses commented that they chaired non-CCG meetings such as meetings with provider trusts. Some open responses indicated that they deputised for the Chair to CCG sub-committees if the Chair was unable to attend.

3.4.2 Satisfaction with impact on the work on the CCG

The vast majority of respondents (84%) were either extremely or fairly satisfied with the impact they had on the work of the CCG.



The open-ended responses illuminate this result with views that the size of the CCG affected the GBN's satisfaction with their impact: "small CCG that believes in quality of care for its population and the needs of the population are at the forefront of everything we do".

The ways of working facilitated the GBN's impact "the matrix working of the CCG and the importance of quality and learning from poor care issues".

Others are confident that they can demonstrate their impact:

"I can evidence the improvements I've made in Patient Safety and Quality"

However, there were some dissatisfied responses, such as:

"It still feels like it's GP led. I think they see me as the 'quality' lead rather than a clinical lead"

"Often feel the financial challenges supercede everything. Not sure role is valued"

"I only get invited to the table late in the decision-making process"

“The nursing input is too compartmented into quality and fails to embrace the skills and knowledge in the team”

“As a result of clinical commissioning, CCG managers are active in seeking GP advice into commissioning plans but do not always seek nursing advice”.

3.4.3 Reasons for wanting to be a nurse on a CCG

This was an open ended response question and elicited a range of responses - the following are representative:

- “To have an impact on population health”
- “Influence commissioning of services”
- “Bringing clinical input to decisions”
- “Ensure nursing is part of commissioning decisions”
- “Be the voice of the patient, voice of the staff”
- “Be close to patients, not too far removed”
- “To bring a non-medical perspective. To lead on patient experience. To bring a focus on quality”

For some participants, being a GBN was a “natural progression” from being a lead nurse on a Primary Care Trust (the precursor to CCGs). For others, it was a case of having to apply due to being made redundant: “I was put at risk – informed I had to apply”. For others, it was an opportunity for career development or to have a post-retirement opportunity.

Some acknowledged the challenges in the role:

- “I enjoy a challenge”
- “Exciting time to join”
- “I enjoy my role but am constantly testing whether I can truly influence”

3.5 Core elements of nursing role on CCG

Some representative responses to this open ended question are shown below.

“To provide assurance (scrutiny) to Governing Body (CCG)...including Safeguarding. To provide an extra clinical voice to strategic decisions. To be an executive director within a commissioning organisation” – this quote illustrates a desire to work on quality services, contribute clinically to strategic decisions and to have an influence as an executive.

Descriptions of assurance included “challenge to the [CCG] Board”

Responses were similar to question 3.4.1 (Chairing Committee experience) and included Safeguarding, Quality, Serious Incidents, Infection Control, Information Governance, Medicines Management, Transformational Change lead or Caldecott Guardian. Some responses indicated the GBN was the clinical specialist lead e.g.: for diabetes. One repeated that “as mentioned I don’t think my nursing experience is valued but rather my ‘quality’ experience. GPs see themselves as the only clinical leads.”

One or two responses indicated they were “practice nurse leads” or “ensured the nursing voice at the executive” or “professional lead for nursing”.

3.6 How is the statutory nurse role different to any other nurse role on CCGs?

While there was acknowledgement that the role varied from CCG to CCG, responses there were divided by different views on whether the statutory role was an executive or non-executive role:

“I am the executive nurse. The GB [statutory] role is quite different, a non-executive director role....about challenge.” full-time statutory and executive nurse

“The statutory role is a non-executive role which should provide challenge to the CCG executives” (full-time statutory and executive nurse)

“scrutiny, assurance and challenge” (part-time statutory nurse / GBN)

“I am a part time non-executive member with full voting rights on the Board” (part-time statutory nurse / GBN)

There were also a range of views regarding whether the role was clinical:

“Mainly paperwork and monitoring of safeguarding and quality. Minimal clinical input” (part-time nurse in executive role)

“We have a practice nurse appointed to the Governing Body. This role brings the voice of practice nursing. Our roles are very different but complementary” (full-time statutory and executive nurse)

For one respondent, the role was about “about ticking a box, and becoming compliant within an authorisation framework” (full-time statutory and executive nurse)

For another it was about “horizon scanning level of assurance” (full-time statutory and executive nurse)

One respondent added that the role was to “represent nursing as a profession [at the Board], to provide leadership to the profession at Board level, to ensure the voice of nurses is heard at Board level” (full-time statutory and executive nurse)

While yet another said that the practice nurse role was “to represent a single profession and has a more local remit. My role allows me to be part of NHS England Directors of Nursing workshops.” (part-time statutory nurse / GBN).

Many comments emphasised the role’s requirement for ‘accountability’, ‘responsibility’ and the role as an “opportunity to have a corporate role.”

There were a small number of responses which saw the role as not being meaningful, one of which echoed earlier comments about GPs’ power: “feels like lip service to GPs.” (full-time statutory and executive nurse). Several respondents pointed out that they were the only nurse role on the CCG and therefore they could not answer the question in the terms it was posed.

3.6.1 Do you think that the statutory nurse role has changed since its introduction?

The explanation for any differences is, perhaps, clear from the following quotes:

“I think people have adapted the role to their specific circumstances.”

“It has evolved as the needs of the organisation become explicit.”

And: “Yes it’s a practically impossible task on 2.5 days per month. The nursing workforce are as many in number as GPs – it should be fairly represented. The CCG nurse is expected to be involved in all aspects of nursing leadership which is far more than the initial expectation.”

“The only change is how individual CCGs choose to deliver this [role]. How seriously they take this role.”

This long quote makes the point about how CCGs need to change to encompass changing patient demand: “Yes I think most CCGs (read GPs for this)⁸ underestimated or had little knowledge of quality, safeguarding and other requirements. I think that understanding has grown to meet those requirements....my personal view is that some CCGs are very medically dominated as the ‘shorthand’ view of clinical leadership is accepted as GPs, and I accept they have much to contribute, but the impact of having nurses and AHPs contributing is much greater. Given the complexity of patients’ needs, the medical needs are often the lesser parts of their presentation. We need to have more clinicians who appreciate integrated working, see it as a partnership of equals, not a medically led model...”

While for some, “I think it has moved from an assurance role to a doing role”

Some adaptation is perhaps shaped by forces external to the CCG:

“Initially the statutory nurse was supposed to have had a bigger input into representing nursing. Unfortunately due to Quality and Safeguarding mandates, this hasn’t happened.”

And one respondent said while the need for change to the role was apparent, human resource issues made this change difficult to effect: “Yes I believe it [the role] was muddled and required clarity. We now have more clarity but unfortunately people are in post...and it’s not that easy to change.”

And another: “I think the hype around the Exec nursing role attracted the wrong candidates in some cases – with minimal experience”

There were 20 respondents who said they were either new in post and could not comment or did not feel there had been any change to the role.

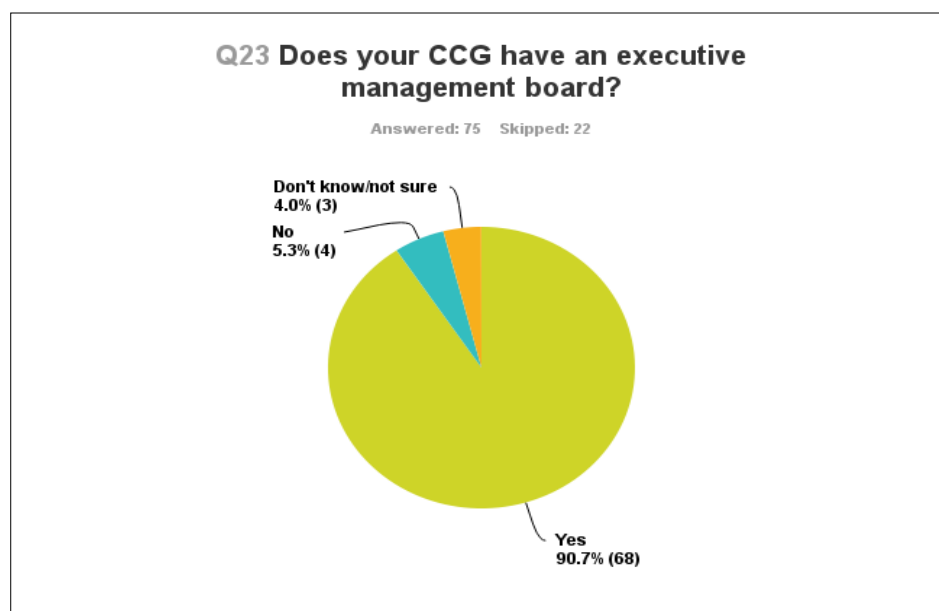
⁸ The parentheses are in the original open ended response

3.7 GBN roles and decision making on CCGs

It can be seen in the data above that a key motivator for GBNs to work on CCGs was to improve the health of the populations served by the CCG through service redesign. The survey asked several questions on the GBN role in relation to CCG decision making.

3.7.1 Executive management boards – existence and membership

Over 90% of respondents said that their CCG has an executive management board. Of those who said that their CCG did have an executive management board, 79.7% reported that they were a member of that board.



3.7.2 Perceived influence on executive management boards –

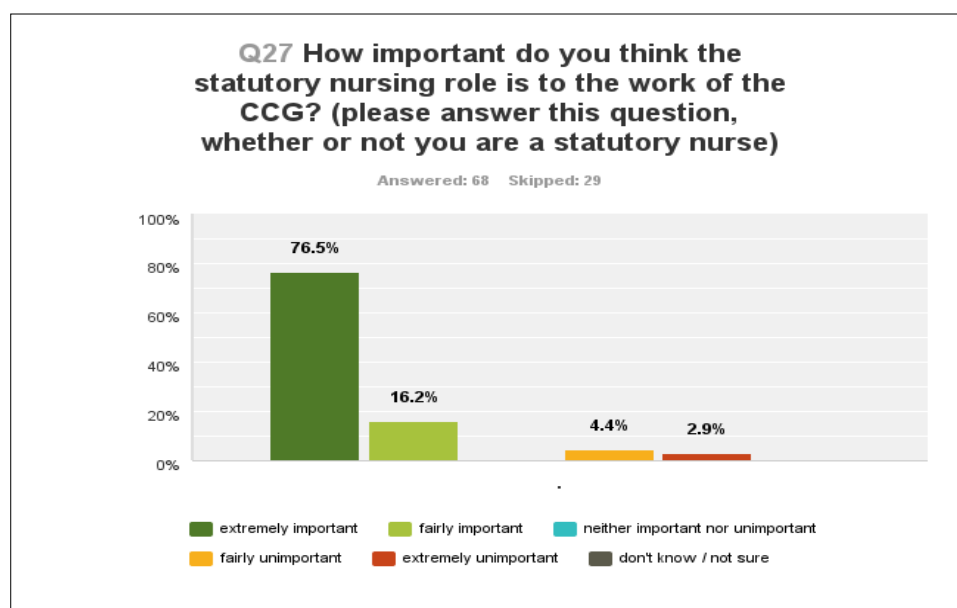
A large majority of respondents (89.1%) felt that they were extremely or fairly influential on management boards. Respondents were invited to say why they felt that they were influential or not influential in a later question (see 3.9).

3.7.3 Reasons for not being on an executive management board

While some of the respondents may have voting rights on the executive team and/or attend executive team meetings, the responses to this question suggest that at least 14 respondents were not influential at all at the executive level because of the way their GBN role was configured in their CCG. The reason given was clear and consistent: their GBN role was not an executive one, which excluded them from decision-making.

3.8 Perceived importance of the statutory nursing role to the CCG

Nearly all respondents (92.7%) considered that the statutory nursing role was important (extremely or fairly) to the work of the CCG.



Respondents were invited to say why they felt that the role was important or not. One respondent said quite simply “Clinical commissioning is not GP commissioning”.

Some responses indicated that there the respondent viewed the GBN role as a generic role i.e. it did not matter that they were a nurse:

“The role of governance and scrutiny is important. It could be any health professional, not necessarily a nurse”

For others, the GBN role provided ‘balance’ as the “GPs could not provide understanding and depth of knowledge of the health services” and “nurses make up the majority of the workforce and have a valued contribution to make”. They are also ‘patient focused’.

While others responded that the nursing role was the right one to undertake quality and governance:

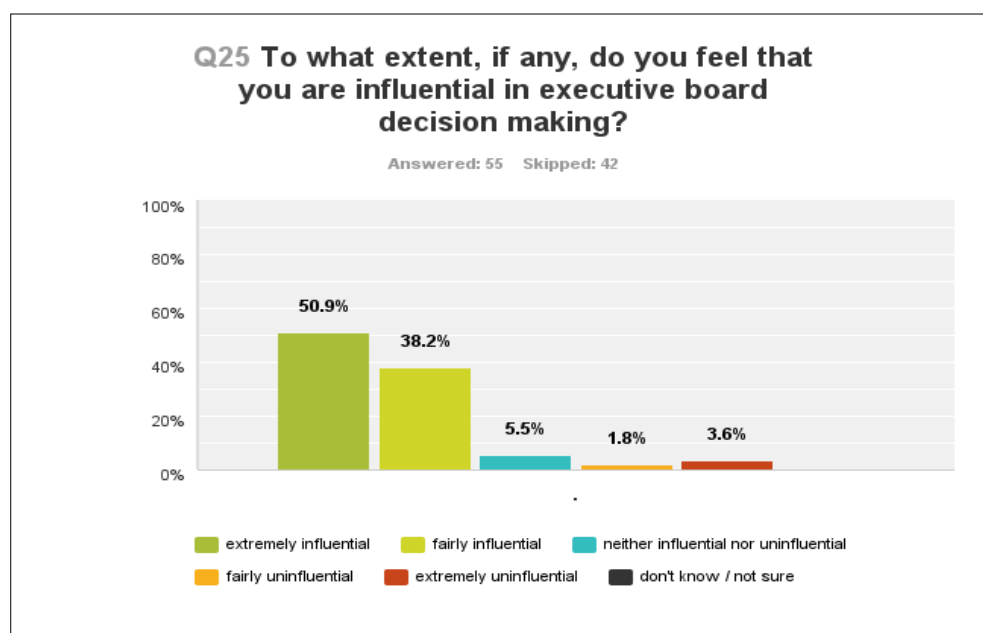
“The [safety, quality] function is essential. The nursing role should deliver this”

Other respondents believed nurses and nursing was not the focus of CCG work:

“I’d say fairly unimportant as CCGs are not interested in nursing contribution as they focus on finance.”

3.9 Perceived influence on executive board decision making

A large majority of respondents (89.1%) felt that there were extremely or fairly influential in executive board decision making.



The open-ended responses show that 15 respondents perceived themselves as influential, partly because of the small size of the CCG:

“Small executive team that has mutual respect for each other”

“I believe I have equal presence at the Board and am able to openly articulate my opinions and concerns openly.”

Some cited ‘evidence’ of their influence:

“Because I raise issues I feel need to be addressed as important”

“Due to personality type, ENTJ, and strengths. Am part of NHS Top Leaders’ team”

This perceived respect was described in the context of the GPs who they worked with:

“...treated as pretty equal to my GP colleagues. I seem to have credibility amongst the GP council and my peer group.”

“Respected as individual and quality seen as central to CCG work”

“Equal member of Director team”

“My opinion is actively and regularly sought and decisions have been supported and opinions changed on the basis of my professional input.”

But there were 13 responses which indicated that the role was not always influential or straightforward:

Such as this respondent who felt s/he influenced through others: “I feel I have the ear of the accountable officer”.

“Not sure that the role is valued”

“Feel that decisions are made before the meetings, GPs hold all of the power”

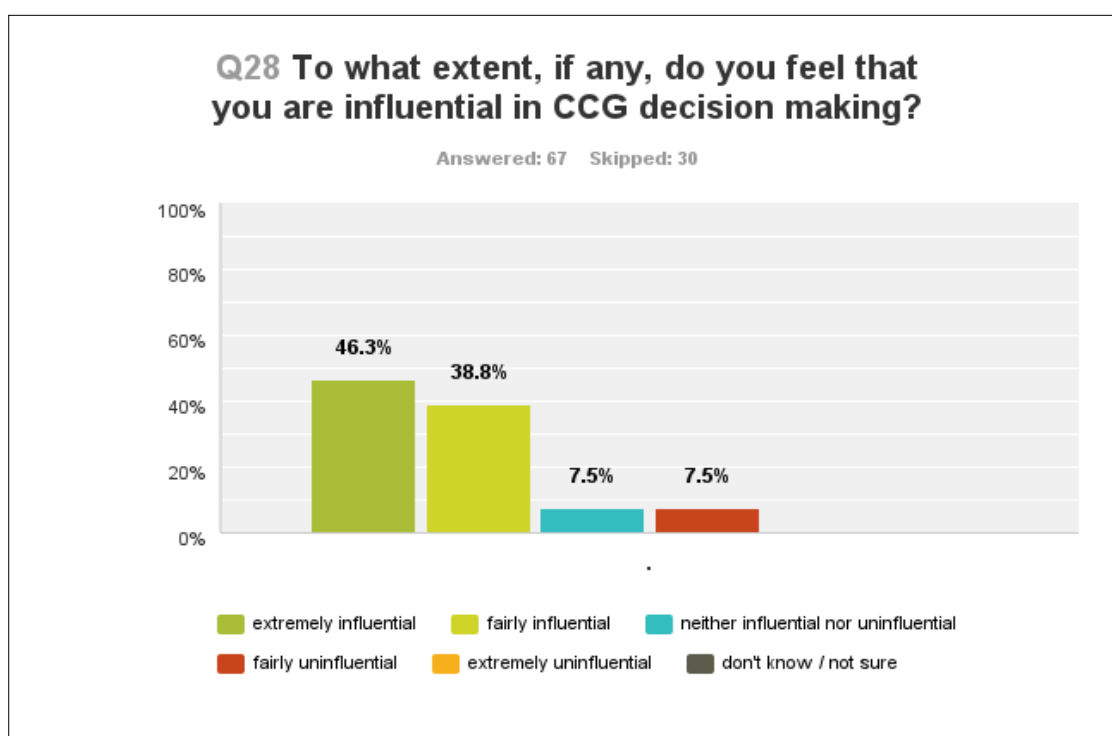
“CCG decision making is medically dominated. There is 1 nurse to 6 GPs. However I do feel I have a voice for patients and nursing”

“The agenda is sometimes dominated by medical opinion”

“Most decisions are driven by finance – while I can sometimes influence these by emphasising clinical risk, we make little headway in addressing the primary causes of poor quality across our system”

3.10 Perceived influence on CCG decision making

A large majority of respondents (85.1%) felt that they were extremely or fairly influential in CCG decision making. This was very similar to the proportion feeling that they were influential in executive board decision making (3.9). The open responses were also very similar to those open responses in 3.9.



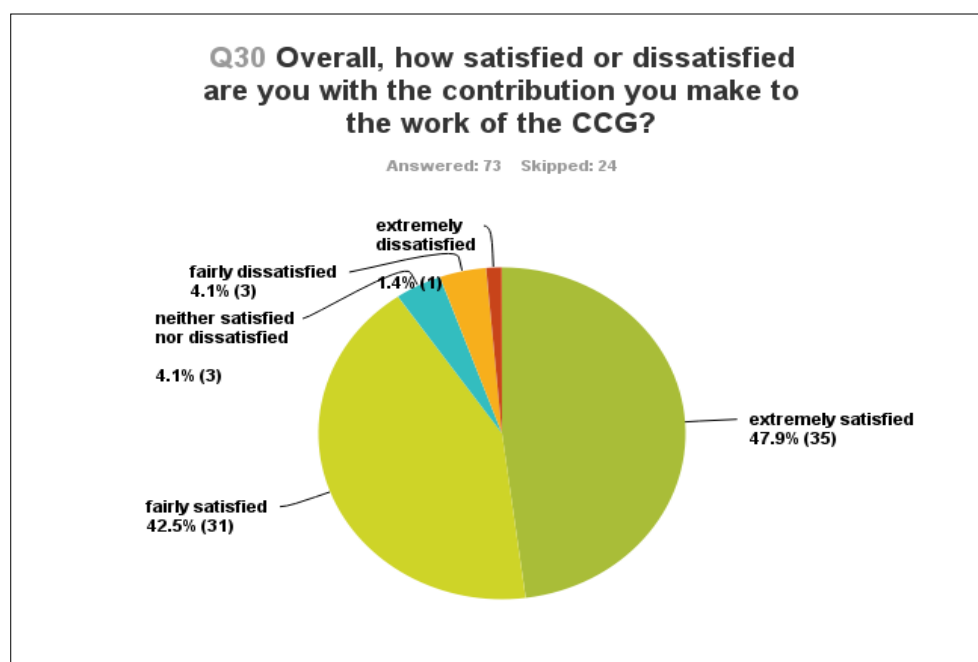
3.10.1 Importance of some committees or roles

Respondents were asked “Generally speaking, are there some committees or roles in your CCG that are more influential in decision-making than others? If so, please say which roles or committees you consider to be most influential”.

Responses varied between a) those who believed committees and roles were of equal value depending on the matter at hand: “They each have their unique purpose. We have undertaken a significant governance review to ensure this”; b) those who considered the finance or accountable officer as the most influential: “Business Committee. Quality and Planning. Finance and Performance”; and c) and those who believed the most influential roles were those of GPs – not because of the role they held in the CCG but because they were GPs and therefore were accorded more intrinsic value: “GP clinical leads”.

3.11 Overall satisfaction with contribution made to work of CCG

More than 90% of respondents were extremely or fairly satisfied overall with the contribution they made to the work of the CCG.



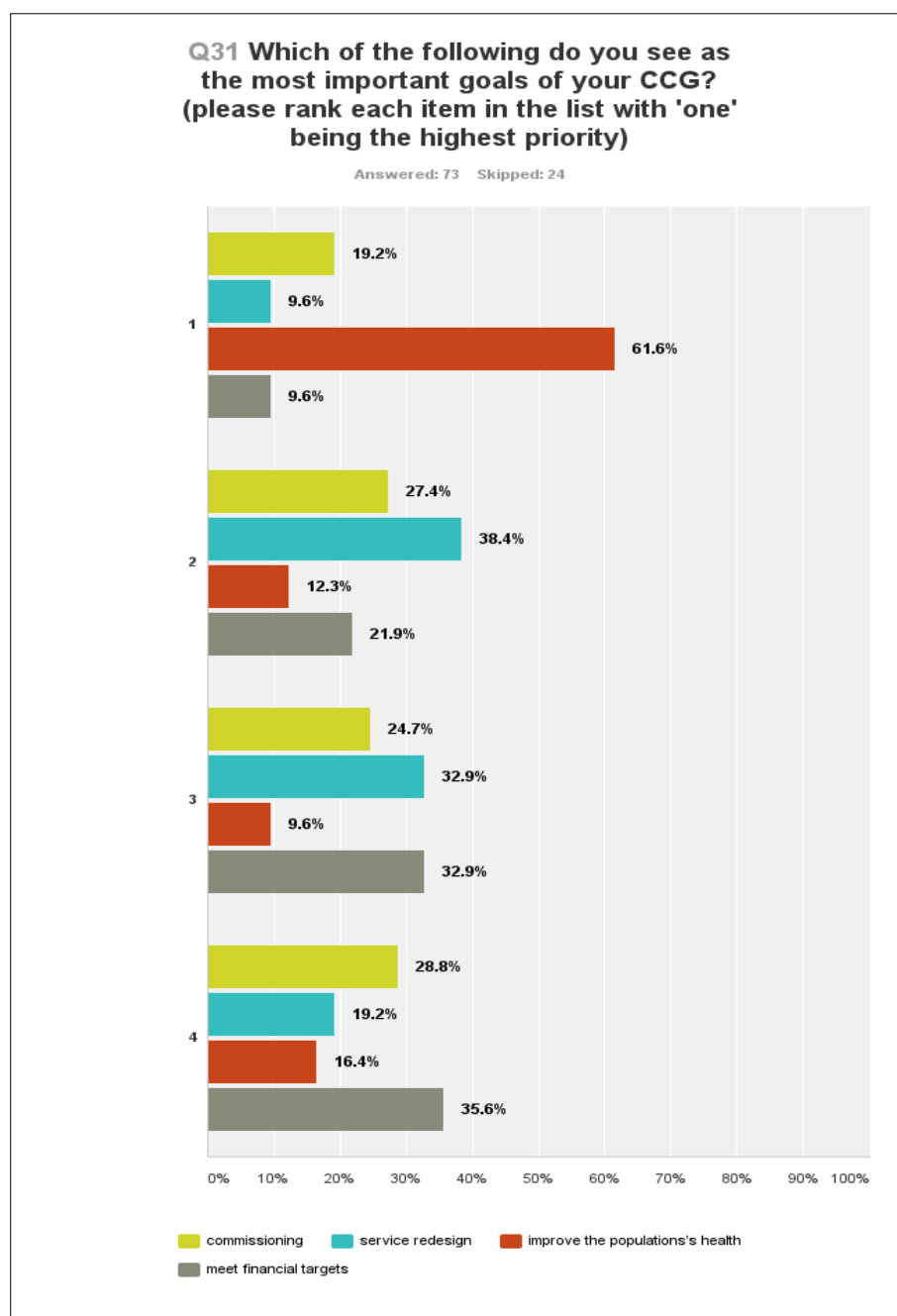
The open responses to this question suggested that respondents felt they had, to a large extent, already addressed the issue in previous questions: (e.g. “see previous answers”). Many responses were repeated: “I feel valued”, “I feel my views are taken seriously”. However, those views which were not repeated - and this was the only place where they emerged - were in the open-ended responses which indicated dissatisfaction; reasons given included: high workload and being part time. Other reasons for dissatisfaction, which had been given before, included: “I feel my clinical knowledge is not utilised to best effect in the commissioning process”; “we [CCGs] continue to be affected by same challenges (finance, performance) as when we started”.

3.12 GBNs' views on the purpose of CCGs

It has been asserted that a key feature of CCGs has been that they are different to other forms of commissioning systems as they place the clinician at the forefront of commissioning decisions. As the results so far show, there is a sense in the responses to the survey that 'clinician' tends to refer to GPs rather than nurses and other AHPS in some CCGs, and that this is a challenge for the respondents who participated in our survey.

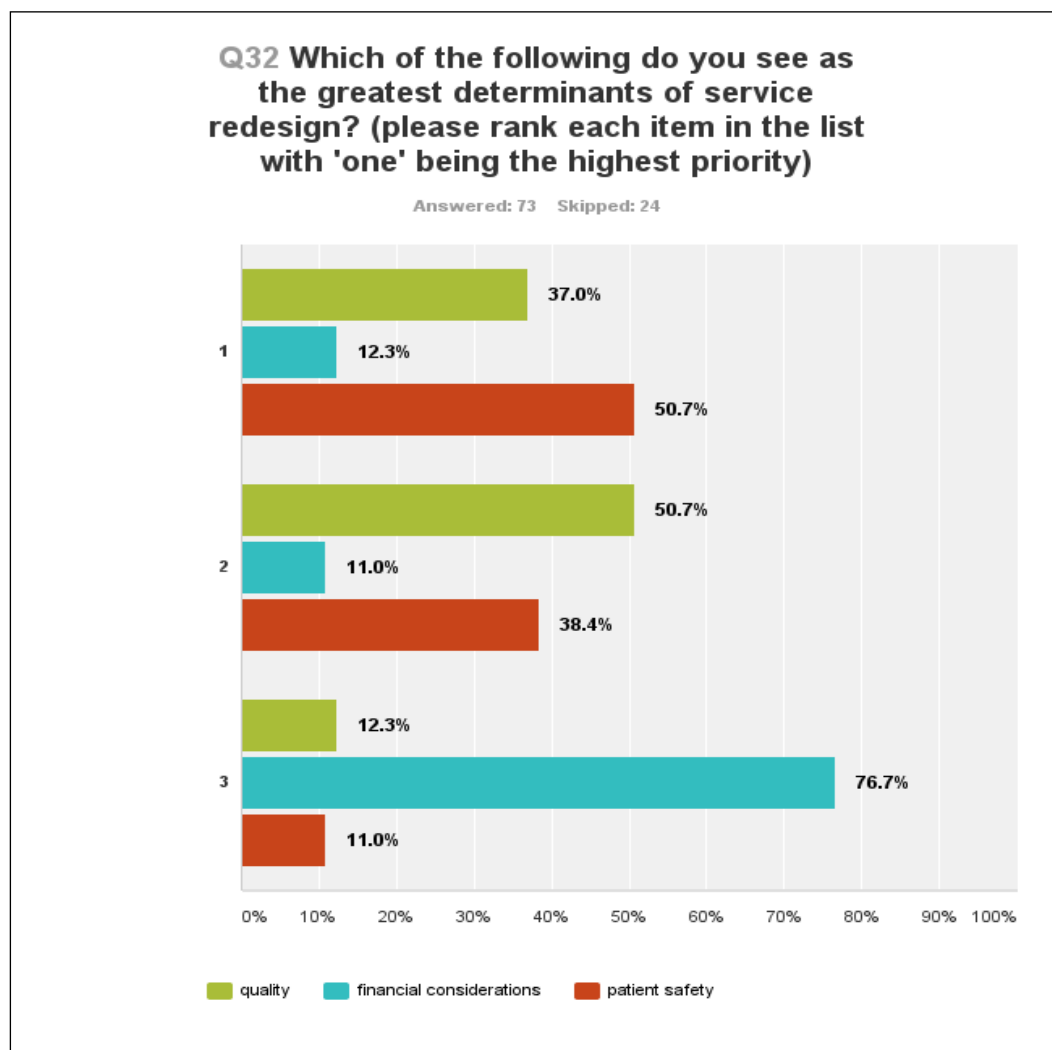
3.13 Prioritising goals for the CCG

Improving the population's health was considered to be the most important goal of their CCG by a significant majority of respondents (61.6%); 19.2% felt that it was commissioning and the remaining responses for the most important goal were evenly split between service redesign and meeting financial targets (each on 9.6%).



3.13.1 Perceived determinants of service design

Patient safety was considered to be the greatest determinant of service redesign by 50.7% of respondents and quality was the most important determinant of redesign in the view of 37% of respondents. 12.3% of respondents considered that financial considerations were the most important determinant of service redesign.



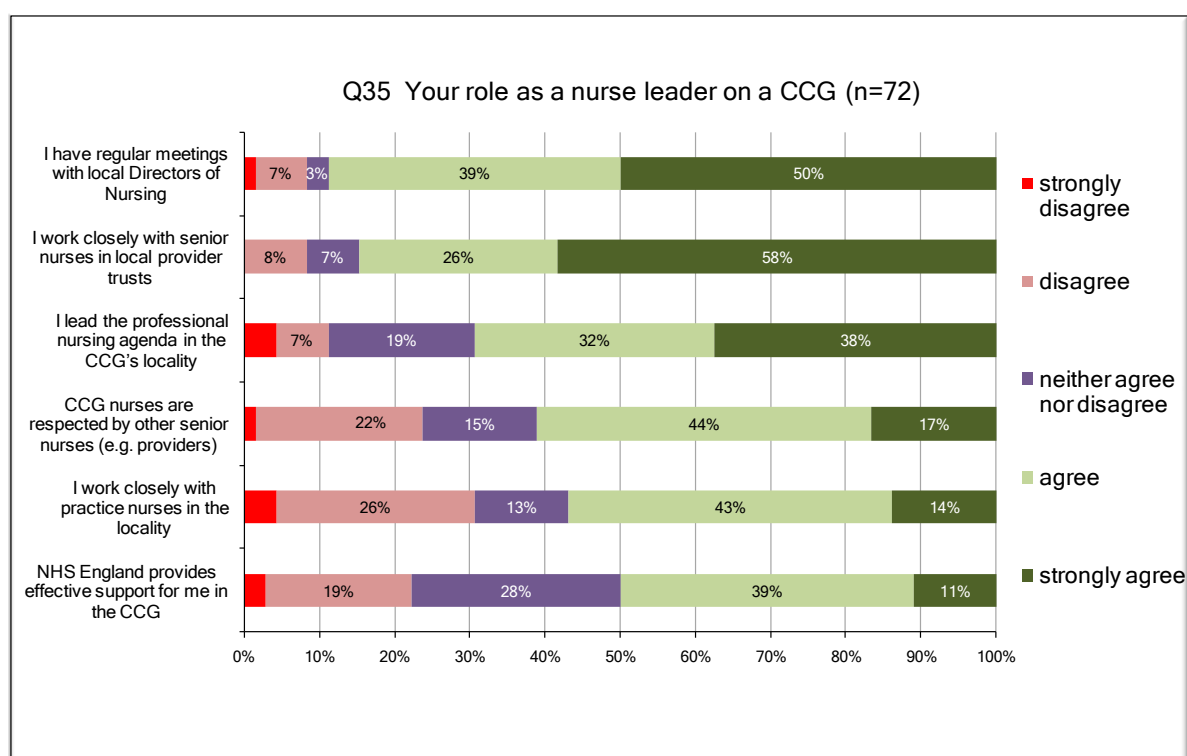
3.14 GBNs' leadership and influence on CCGs

3.14.1 Your role as a nurse leader on a CCG and with local stakeholders

Respondents were asked to respond to a series of Likert scale items regarding their attitudes to certain aspects of their role as a nurse on a CCG. There was a high level of agreement with all the statements, but agreement was highest with the statements: 'I work closely with senior nurses in local provider trusts' (mean 4.35); 'I have regular meetings with local Directors of Nursing' (mean 4.29). Agreement was lowest in relation to 'I work closely with practice nurses in the locality' (mean 3.36).

Questionnaire item	Mean (average of scores where 1 = strongly disagree and 5 =strongly agree) Ranked in descending order
I work closely with senior nurses in local provider trusts	4.35
I have regular meetings with local Directors of Nursing	4.29
I lead the professional nursing agenda in the CCG's locality	3.92
CCG nurses are respected by other senior nurses (e.g. providers)	3.53
I work closely with practice nurses in the locality	3.36
NHS England provides effective support for me in the CCG	3.36

The chart below shows the same data but in percentage terms, rather than means. The items with the highest proportion of neutral or negative responses are: 'NHS England provides effective support for me in the CCG'; 'I work closely with practice nurses in the locality' and 'CCG nurses are respected by other senior nurses (e.g. providers)'.



3.14.2 Leadership role within CCGs and confidence in carrying it out

Responses to open-ended questions about the GBN's leadership role typically came under the following themes:

- Values based leadership
- Visible and practical leadership
- Expertise based leadership
- Facilitating and developing colleagues through empowerment leadership style
- Role modelling leadership behaviour
- Working across the CCG and with external partners

These attributes are typified in some of the following quotes:

"I provide leadership in a number of ways – firstly as a team leader within the CCG, for the staff within that team; through influence and supporting people to become empowered within their roles; by involving colleagues and listening; I give of myself in terms of time, listening, being accessible. I chair or am active within safeguarding boards to give the message to trusts about the importance of safeguarding. I try and be a good role model through behaviour, and embody my values and when appropriate make decisions and stand by them. I don't lead by making all the decisions – I try and offer a varied approach to each situation".

However, while a GBN perceives s/he has a leadership role across the CCG locality: "care homes, practice nursing, quality in contracts and influencing providers", this leadership was "not always valued by others. Directors of Nursing don't value the CCG Director of Nursing role".

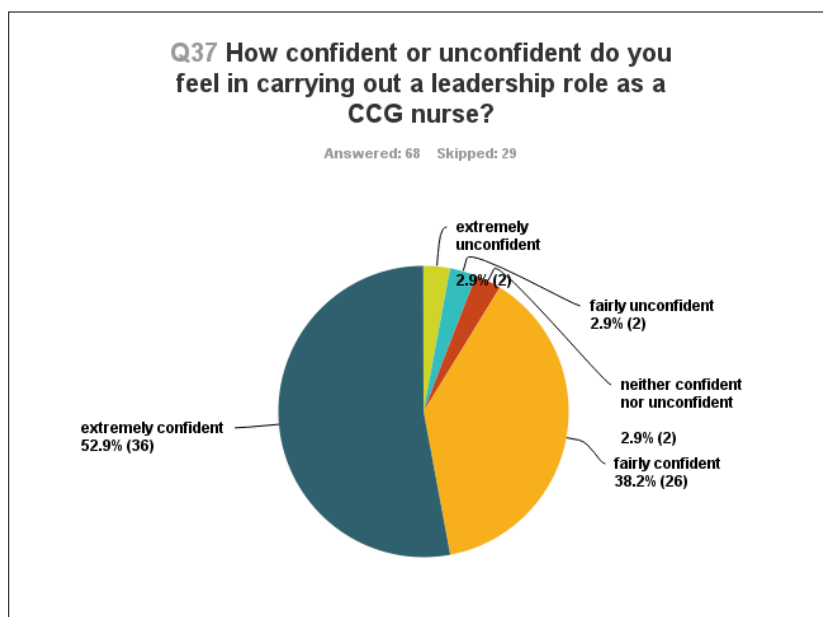
This suggests that providing leadership across the CCG locality is a challenge, even though there were many answers to this question, including the following responses:

Providing leadership indirectly through: "Strategic direction over a number of areas"
"transformational leadership ...leading by example" "acting as a role model" "conscience of organisation" "professional leadership on the nursing agenda."

While more directly: "I'm seen as a point of contact for practice nurses, help, support practice nurses, I keep the practice nurses on as many agendas as I can", "team lead within CCG for Quality....part of senior leadership team", "I lead a small team".

3.14.3 Confidence in their leadership role

95.8% of respondents felt that they had a leadership role within their CCG (not shown in the chart). More than half of respondents (52.9%) said that they were 'extremely confident' in carrying out their leadership role and a further 38.2% were 'fairly confident'.



Open responses to this question included:

"I have been given support by the Chief Officer and other executives. Expectations of me are high and that feels good"

One respondent described having a "clear role and expectations" and "Being given opportunities to lead a number of cross work streams."

Attributes conducive to feeling confident in providing leadership included: "Years of experience", "experienced leader with a range of leadership roles across the NHS", "level of autonomy in the [GBN] role", being "an experienced leader who takes self-development seriously", "feeling valued", "growing confidence with increased knowledge of the commissioning landscape", "working to high standards, [being] respected by my peers within the CCG and externally to the CCG",

There were a small number of comments reflecting a lack of confidence in carrying out a leadership role:

"I feel I do but am overstretched"

"I feel I understand the role and have the skills to achieve this – it's just the role and the environment which are becoming less fulfilling"

3.14.4 Support needed to fulfil CCG role

Responses to this open-ended question gave a number of suggestions for support including:

- Mentorship, both internally to the CCG and externally; this may include mentorship with or from other senior nurses in the CCG locality.
- Coaching
- Peer support from within the commissioning network and from the NHS England regional and sub-regional groups.

- Support from NHS England including the NHS England Leadership Academy
- Networking
- Good administrative [Personal Assistant] support

When asked which organisations this support should come from, responses included:

- Professional organisations i.e. The Royal College of Nursing
- NHS England and the Chief Nursing Officer for England
- Health Education England
- The respondent's own CCG

4 Conclusion

The survey results illuminate the role and potential of the GBN role within CCGs and nurses working in CSUs through the perceptions of those nurses. We have presented five main areas of findings which concern: i) the tensions between CSUs and CCGs ii) motivations, roles and experiences of GBNs working on CCGs, iii) self-rated observations of GBNs on the influence of their roles on decision making on CCGs, iv) GBNs' views of the perceived purpose of CCGs, GBNs' leadership and influence on CCGs.

Taken together, these findings paint a picture of GBNs as a body of highly experienced and qualified nurses, apparently fully engaged with the challenges and opportunities of the nursing role within the newly formed CCGs.

However, there are some reasons for having reservations about how the nursing role within CCGs is developing. It has been asserted that a key feature of CCGs is that they are different to other forms of commissioning systems by placing the clinician at the forefront of commissioning decisions. There is a suggestion from some open-ended responses in the survey that, in some CCGs, 'clinician' tends to refer to GPs or other AHPs, rather than nurses, and that this is a challenge for GBNS and nurses in CSUs.

On the whole, GBNs appear satisfied with their overall contribution to CCGs and with the impact which they have on decision making. Their motivations in working either as GBNs or senior nurses within CSUs are, most commonly, to ensure a nursing dimension in CCG decision making and to be an advocate for patient interests. Respondents may well be correct about the influence or impact which they have in relation to CCGs but obviously, this cannot be reliably determined through survey data alone. We cannot tell from this research if nurses' perceptions of their influence or impact on CCGs, or ultimately, on the nature and standard of care commissioned by the CCG is justified. That is partly because a survey methodology (which is restricted to nurses in CCGs/CSUs) is not suited to such a research question, but also because of the relative immaturity of CCGs, and therefore the roles within them. Respondents had typically been in post for more than two years and so were in a position to give a considered and informed response about their role, but it is important to note that CCGs and CSUs, and the nursing roles within these, are still quite new and it is hard to judge what the impact of nurses within CCGs will ultimately be. Oates et. al (2014:59) acknowledge that CCGs are still at a formative stage, and it is unclear what leverage they may eventually have in ensuring that commissioned services are delivered, as contractually agreed, but they highlight the importance of the nursing role in developing the effectiveness of CCGs:

"Nurse input is vital to the success of any healthcare commissioning approach, given that nursing incorporates such a diverse workforce with a breadth of experience and expertise. Nursing is the

largest profession in health care, with a membership well versed in multiprofessional and integrated working. Nurses also traditionally championed the patient voice and patient experience. Therefore, there is scope for collaboration and consensus between nurses in CCGs and public members within patient forums, representative groups and governing bodies”.

Although there was only a small number of nurses in CSUs in the data (n=7), it seemed that their experiences were somewhat in contrast to that of GBNs. The majority were dissatisfied with the impact that they had on CCGs and seemed to feel undervalued or marginalised. Clearly the reasons underlying this must be understood and addressed.

The respondents (both GBNs and those in CSUs) were mostly women over 50, of White or White British ethnicity. This would seem to support Mc Cann et. al's (2014) argument that succession planning is needed to achieve more diversity amongst commissioning nurses so that they reflect more accurately the diversity in the nursing workforce and amongst the variety of populations served by CCGs.

4.1 Final thoughts

While there are many positive aspects in these findings regarding the nursing role in CCGs, the open-ended responses show that the influence and impact of the GBN role may, in some instances, be limited by certain assumptions or ways of working, particularly the perception that the GP is the lead clinician in the CCG. Achieving the goals of the CCGs may therefore be under threat if the contributions of GBNs, nurses in CSUs and AHPs go unrecognised or underutilised. Further research, perhaps going beyond survey methodology, is needed to investigate how GBNs and nurses within CSUs may be best able to impact on the work of CCGs as those organisations mature and the roles become embedded.

5 Appendices

5.1 Appendix 1: online survey

A pdf of the survey can be obtained from the authors of the report, on request.

The online survey can also be accessed via this url:

<https://www.surveymonkey.net/r/?sm=kWYpk3gCBQ%2bPvTSBJtRiVokcD%2b5u5dK58jolcjpV%2br6ZgYqpYPioVeFIglpnS51UGspTzR1ETIUzr83vPfMG4roTRLTF%2fmd%2ff1DfV5p%2fVDw%3d>

5.2 Appendix 2 invitation email to survey

Dear [FirstName],

Have your say! -Independent annual survey of CNL Network members regarding your work as Commissioning Nurses in CCGs or CSUs

You are being invited to take part in this study because you are a nurse working in a Clinical Commissioning Group (CCG) or a Commissioning Support Unit (CSU) in England.

You are being asked to participate in a national survey which is devised by Professor Helen Allan and Mike O'Driscoll at Middlesex University. The purpose of this survey is to understand CCGs and the roles of nurses working with these groups.

NHS England has contributed significantly to the questionnaire design and has supplied the contact details for potential participants but the research is independent of NHS England. NHS England will not be able to identify your responses.

Here is a link to the survey:
[SurveyLink]

The closing date is Friday, 19th June (at 11pm).

All information which is collected about you during the course of the research will be kept strictly confidential. Your responses will only be used in anonymised form - they will not be associated with your name or email address so that you cannot be recognised from them.

All data will be stored, analysed and reported in compliance with the data protection legislation of the United Kingdom where the study is being conducted.

You can find further information about the study in the participant information sheet, which you can download here <https://nursesonccgs.files.wordpress.com/2015/05/may-2015-ccgpis-final.doc>.

Your participation is greatly appreciated and we hope you will find the questionnaire interesting.

If you have any questions please contact Mike O'Driscoll (m.o'driscoll@mdx.ac.uk) or Professor Helen Allan (h.allan@mdx.ac.uk).

We look forward to hearing your views!

This link is uniquely tied to this survey and your email address. Please do not forward this message.

5.3 Participant Information Sheet

MIDDLESEX UNIVERSITY SCHOOL OF HEALTH AND EDUCATION

Health and EDUCATION ethics SUB-committee

1. National online survey to explore Nurses' experiences of clinical commissioning groups

2. Invitation paragraph

You are being invited to take part in a research study. Before you decide whether to take part or not, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please get in touch if there is anything that is not clear or if you would like more information (our contact details are at the bottom of page 2).

Thank you for reading this.

3. What is the purpose of the study?

The purpose of this study is to understand Clinical Commissioning Groups (CCGs) and the roles of nurses appointed to these groups. You are being asked to participate in a survey which will be distributed to all nurses appointed to CCGs in England including CMRNs.

4. Why have I been chosen?

You have been chosen because you are a nurse appointed to a CCG in England.

5. Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason.

6. What will happen to me if I take part?

You are being asked to participate in an online survey which will take approximately 15 minutes to complete.

Please note that in order to ensure quality assurance and equity this project may be selected for audit by a designated member of the committee. This means that the designated member can request to see your name. However, if this is the case your name will only be accessed by the designated auditor or member of the audit team.

7. What do I have to do?

You are invited to complete an online survey, giving your answers to opinions on various aspects of being a nurse on a CCG. .

8. What are the possible disadvantages and risks of taking part?

There are no possible physical disadvantages or risks to taking part.

9. What are the possible benefits of taking part?

There is no intended benefit to the participant from taking part in the study but your participation will add to the body of knowledge of senior nursing roles in commissioning bodies. Many people find that being able to express their views and relate their experiences is a positive experience.

10. Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and email address removed so that you cannot be recognised from it.

All data will be stored, analysed and reported in compliance with the Data Protection Legislation of the United Kingdom where the study is being conducted.

11. What will happen to the results of the research study?

The results of this research will be distributed to all nurses working on CCGs in England. The results will also be published in a peer reviewed journal. You may if you wish contribute or comment on this paper. You will be contacted with the final draft before submission for publication. This should be ready for publication 2015/16. You will not be identified in any report/publication.

12. Who has reviewed the study?

The Middlesex University, School of Health and Social Sciences, Health Studies Ethics sub-Committee has reviewed this study.

13. Contact for further information about the study

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Many thanks for reading this information sheet and considering whether to participate in this study.

6 References

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